

# **Audit**



# **Report**

OFFICE OF THE INSPECTOR GENERAL

**BASE REALIGNMENT AND CLOSURE BUDGET DATA  
FOR THE NAVAL HOSPITAL LEMOORE, CALIFORNIA**

Report No. 95-258

June 28, 1995

**Department of Defense**

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### **Acronyms**

BRAC	Base Realignment and Closure
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
COBRA	Cost of Base Realignment Actions
MEDCEN	Medical Center
MILCON	Military Construction
NAS	Naval Air Station
NH	Naval Hospital
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)

June 28, 1995

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE (COMPTROLLER)  
ASSISTANT SECRETARY OF DEFENSE (HEALTH  
AFFAIRS)  
ASSISTANT SECRETARY OF THE NAVY (FINANCIAL  
MANAGEMENT AND COMPTROLLER)

SUBJECT: Audit Report on Base Realignment and Closure Budget Data for the Naval  
Hospital Lemoore, California (Report No. 95-258)

We are providing this audit report for your review and comment. This report is one in a series of reports about construction costs for Defense base realignment and closure and is the second report related to the Naval Medical Center Oakland, California, base realignment and closure package. The report also covers a related non-base realignment and closure military construction project. We considered management comments on a draft of this report in preparing the final report.

DoD Directive 7650.3 requires that all audit recommendations and potential monetary benefits be resolved promptly. The Assistant Secretary of Defense (Health Affairs) and the Under Secretary of Defense (Comptroller) generally concurred with the recommendations. The Under Secretary deferred action until the Assistant Secretary has completed a revalidation of the requirements for the replacement project. We request additional comments from the Assistant Secretary of Defense (Health Affairs) on Recommendation 1.b. by August 28, 1995.

We appreciate the cooperation extended to the audit staff. If you have any questions on the audit, please contact Mr. Michael A. Joseph, Audit Program Director, or Mr. Jack L. Armstrong, Audit Project Manager, at (804) 766-2703. See Appendix G for the report distribution. The audit team members are listed on the inside back cover.



Robert J. Lieberman  
Assistant Inspector General  
for Auditing

## Office of the Inspector General, DoD

Report No. 95-258  
(Project No. 4CG-5008.20)

June 28, 1995

### BASE REALIGNMENT AND CLOSURE BUDGET DATA FOR THE NAVAL HOSPITAL LEMOORE, CALIFORNIA

#### EXECUTIVE SUMMARY

**Introduction.** Public Law 102-190, "National Defense Authorization Act for Fiscal Years 1992 and 1993," December 5, 1991, directs the Secretary of Defense to ensure that the amount of the authorization DoD requested for each military construction project associated with base realignment and closure does not exceed the original cost estimate provided to the Commission on Defense Base Closure and Realignment (the Commission). If the requested budget amounts exceed the original project cost estimate provided to the Commission, the Secretary of Defense is required to explain to Congress the reasons for the differences. A primary reason for differences is the rigid time constraints imposed on the Military Departments for developing cost estimates for base realignment and closure military construction. The Inspector General, DoD, is required to review each military construction project for which a significant difference exists from the original cost estimate and to provide the results of the review to the congressional Defense committees.

This report is one in a series of reports relating to base realignment and closure budget data and is the second report relating to the base realignment and closure package for the Naval Medical Center Oakland, California. The report provides the results of the audit of two construction projects to replace the hospital at the Naval Hospital Lemoore at a total cost of \$47.2 million. Project 25845 was for the construction of a replacement hospital for the existing hospital with an estimated construction cost of \$38.2 million (\$37 million FY 1996 Military Construction Funds and \$1.2 million equipment funds). Project 43827 was for a \$9 million (FY 1997 Base Closure Account Funds) expansion of Project 25845.

**Objectives.** The overall audit objective was to determine the accuracy of budget data for the base realignment and closure military construction. The specific objectives were to determine whether the proposed military construction projects were valid base realignment and closure requirements, whether the decision for military construction was supported with required documentation including an economic analysis, and whether the analysis considered existing facilities. We also evaluated a non-base realignment and closure military construction project (project 25845) because it was the basis for the base realignment and closure military construction project. The audit also evaluated the adequacy of the management control program as it relates to the audit objectives.

**Audit Results.** A replacement hospital at Naval Hospital Lemoore was not economically justified. By reducing the construction project from a replacement hospital to a clinic, DoD can put \$27.6 million of Military Construction and Base Closure Account funds, and \$11.5 million of Operations and Maintenance funds to better use (see finding in Part II). Appendix E summarizes the potential benefits resulting from the audit.

The Office of the Assistant Secretary of Defense (Health Affairs) has identified military construction as high risk and is planning to improve management controls. The Navy has identified military construction as medium risk and is planning to conduct a management control review in FY 1995. We did not make recommendations to improve the validation of project requirements because of management actions being taken in response to a prior audit report. Part I contains a description of the management controls assessed and Part II includes a discussion of the management control deficiencies.

**Summary of Recommendations.** We recommend that the Assistant Secretary of Defense (Health Affairs) reduce the hospital replacement project to a clinic and modify the economic analysis manual to require the use of actual cost data. We also recommend that the Under Secretary of Defense (Comptroller) reduce the Military Construction and Base Closure Account funds for the replacement project.

**Management Comments.** The Deputy Assistant Secretary of Defense (Health Services Operations and Readiness) stated that the replacement project would be revalidated by the end of June 1995 and actual costs should be a factor when performing future cost analysis. The Assistant Deputy Comptroller (Program/Budget) has placed the project funds, Military Construction and Base Closure Account, on administrative hold until the Deputy Assistant Secretary completes the requirements revalidation. See Part II for a summary of management comments and Part IV for the complete text of management comments.

**Audit Response.** Because DoD has recommended to the 1995 Base Realignment and Closure Commission that the 1993 realignment from Naval Air Station Miramar to Naval Air Station Lemoore be changed, we agree that the replacement project should be revalidated and a new economic analysis be performed. We will review the revalidation and economic analysis when it is completed. However; we request that the Assistant Secretary of Defense (Health Affairs) provide clarification by August 28, 1995 on the recommendation to update the economic analysis manual. Based on discussions with personnel from the Office of the Assistant Secretary of Defense (Health Affairs), we deleted a section of the report on population and workload projections and modified the section on the management control program.

# Table of Contents

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<b>Executive Summary</b>	<b>i</b>
<b>Part I - Introduction</b>	
Background	2
Objectives	3
Scope and Methodology	3
Management Control Program	4
Prior Audits and Other Reviews	5
<b>Part II - Finding and Recommendations</b>	
Construction Requirements	8
<b>Part III - Additional Information</b>	
Appendix A. Prior Audits and Other Reviews	22
Appendix B. Map of the Naval Hospital Lemoore Catchment Area and Selected Civilian Hospitals	25
Appendix C. Methodology for Calculating Average Inpatient Costs and Cost Differential	26
Appendix D. Catchment Area Hospitals	29
Appendix E. Summary of Potential Benefits Resulting From Audit	30
Appendix F. Organizations Visited or Contacted	31
Appendix G. Report Distribution	33
<b>Part IV - Management Comments</b>	
Under Secretary of Defense (Comptroller) Comments	36
Assistant Secretary of Defense (Health Affairs) Comments	37

## **Part I - Introduction**

## Background

**Initial Recommendations of the Commission on Defense Base Closure and Realignment.** On May 3, 1988, the Secretary of Defense chartered the Commission on Defense Base Closure and Realignment (the Commission) to recommend military installations for realignment and closure. Using cost estimates provided by the Military Departments, the Commission recommended 59 realignments and 86 base closures. On October 24, 1988, Congress passed, and the President signed, Public Law 100-526, "Defense Authorization Amendments and Base Closure and Realignment Act," which enacted the Commission's recommendations. Public Law 100-526 also established the DoD Base Closure Account to fund any necessary facility renovation or military construction (MILCON) projects related to base realignment and closures (BRAC).

**Subsequent Commission Requirements and Recommendations.** Public Law 101-510, "Defense Base Closure and Realignment Act of 1990," November 5, 1990, reestablished the Commission. Public Law 101-510 chartered the Commission to meet during 1991, 1993, and 1995 to provide a fair process for the timely and independent realigning and closing of military installations. The law also stipulated that realignment and closure actions must be completed within 6 years after the President transmits the recommendations to Congress.

The 1991 Commission recommended that an additional 48 bases be realigned and 34 be closed, resulting in an estimated net savings of \$2.3 billion for FYs 1992 through 1997 after a one-time cost of \$4.1 billion. The 1993 Commission recommended that 45 bases be realigned and 130 bases be closed, resulting in an estimated net savings of \$3.8 billion during FYs 1994 through 1999, after a one-time cost of \$7.4 billion.

**Military Department BRAC Cost-Estimating Process.** To develop cost estimates for the Commission, the Military Departments used the Cost of Base Realignment Actions (COBRA) computer model. COBRA uses standard cost factors to convert suggested BRAC options into dollar values to provide a way to compare different options. After the President and Congress approve the BRAC actions, DoD realignment activity officials prepare DD Form 1391, "Military Construction Project Data," for individual construction projects required to accomplish the realignment actions. COBRA provides cost estimates as a BRAC package for a particular realigning or closing base. DD Form 1391 provides specific cost estimates for an individual BRAC MILCON project.

**Defense Reviews of BRAC Estimates.** Public Law 102-190, "National Defense Authorization Act for Fiscal Years 1992 and 1993," December 5, 1991, stated that the Secretary of Defense shall ensure that the authorization amount that DoD requested for each MILCON project associated with BRAC actions does not exceed the original estimated cost provided to the Commission. If the requested budget amounts exceed the original project cost estimates provided to the Commission, then the Secretary is required to explain to Congress the reasons for the differences. Public Law 102-190 also



prescribed that the Inspector General, DoD, evaluate significant increases in construction project costs over the estimated costs provided to the Commission, and send a report to the congressional Defense committees.

## Objectives

The overall audit objective was to determine the accuracy of budget data for the BRAC MILCON. The specific objectives were to determine whether the proposed MILCON projects were valid BRAC requirements, whether the decision for MILCON was supported with required documentation including an economic analysis, and whether the analysis considered existing facilities. We also evaluated a non-BRAC MILCON project because it was the basis for the BRAC MILCON project. The audit also assessed the adequacy of the management control program as it relates to the audit objectives.

## Scope and Methodology

**BRAC Package Selection Process.** COBRA develops cost estimates as a BRAC package for a particular realignment or closing base, but does not develop estimates by individual BRAC MILCON project. We compared the total COBRA cost estimates for each BRAC package to the Military Departments' and Defense Logistics Agency's FYs 1994 through 1999 BRAC MILCON \$2.6 billion budget submission. In FY 1994, we selected BRAC MILCON packages for which:

- o the package had an increase of more than 10 percent from the total COBRA estimates to the current total package budget estimate, or
- o the submitted budget estimates increased by more than \$21 million.

**Selection of Projects for Audit.** In a March 1993 memorandum, the Chief of Naval Operations projected that the closure of the Naval Medical Center (MEDCEN) Oakland, California, would result in new construction only at the MEDCEN San Diego, California. The COBRA computer model projected that the closure of MEDCEN Oakland would require about \$25.4 million in new construction. After the March 1993 memorandum was issued, MEDCEN Portsmouth, Virginia; Naval Hospital (NH) Bremerton, Washington; MEDCEN San Diego, California; and NH Lemoore, California, submitted BRAC MILCON projects, increasing the total MEDCEN Oakland BRAC package cost to \$39.7 million.

The above selection criteria were applied to the total \$39.7 million cost for the MEDCEN Oakland BRAC package. For this audit, we limited our review to the hospital replacement project, with an estimated cost of \$47.2 million (Base Closure Account and MILCON funds), at NH Lemoore.

## **Introduction**

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The Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]) replacement project consisted of two projects. Project 25845 was for the construction of a replacement hospital for the existing hospital at NH Lemoore with an estimated construction cost of \$38.2 million (\$37 million FY 1996 MILCON funds and \$1.2 million equipment funds). The project was not justified on BRAC actions. Project 43827 was for a \$9 million (FY 1997 Base Closure Account funds) expansion of project 25845 as the result of BRAC and was included in the MEDCEN Oakland package.

**Examination Process.** We examined the FY 1996 MILCON budget requests and related documentation regarding the closure of the MEDCEN Oakland and realignment of medical personnel to the NH Lemoore. We reviewed supporting documentation for the MILCON project planned for NH Lemoore. The review included FY 1991 through FY 1993 NH Lemoore budget, cost, and workload data, and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) cost and workload data for the catchment area (the area within a 40-mile radius of the hospital). We reviewed the economic analysis procedures and verified the data used in the analyses.

**Computer-Processed Data.** We used data obtained from the Defense Medical Information System to verify the accuracy of the economic analysis. Specific Defense Medical Information System data used were NH Lemoore and CHAMPUS cost, work load, and catchment area population. We reviewed the supporting information that OASD(HA) developed to validate the information used in the economic analysis. We also performed a limited test of the accuracy of NH Lemoore FY 1993 operating costs and FY 1998 projected population data. We did not verify the accuracy of NH Lemoore workload data or CHAMPUS cost and workload data. A more detailed review will be made of the Defense Medical Information System cost and workload accounting systems in a future audit.

**Audit Standards and Locations.** This economy and efficiency audit was made from May 16 through October 27, 1994. The audit was made in accordance with auditing standards issued by the Comptroller General of the United States, as implemented by the Inspector General, DoD. Accordingly, the audit included tests of management controls as were considered necessary. We did not rely on statistical sampling procedures. Appendix F lists the organizations visited or contacted during the audit.

## **Management Control Program**

**Management Controls Assessed.** We evaluated the OASD(HA) and Navy management control program for validating MILCON requirements.

**Adequacy of Management Controls.** OASD(HA) validated the MILCON project requirements consistent with existing guidance. We identified a material management control weakness as defined by DoD Directive 5010.38, "Internal Management Control Program," April 14, 1987, for the hospital replacement

projects. Navy management controls were not adequate to ensure that the project requirements were adequately validated. We are not making recommendations to the Navy to improve procedures for validating MILCON project requirements because recommendations were made in Inspector General, DoD, Report No. 94-125, and corrective action is in process.

**Adequacy of the Management Control Self-Evaluation Process.** The OASD(HA) and Navy management control self-evaluation processes were adequate as they related to the audit objectives. OASD(HA) has identified MILCON as high-risk and is planning to improve management controls. The Navy identified MILCON as medium risk and is planning to conduct a management control review in FY 1995. The details are discussed in Part II. A copy of the report will be provided to the senior official responsible for management controls in the OASD(HA) and the Navy.

## Prior Audits and Other Reviews

Appendix A contains summaries of General Accounting Office and Inspector General, DoD, audits and an OASD(HA) study that discusses issues related to the construction of military treatment facilities. Additionally, since FY 1991, numerous audit reports have addressed DoD BRAC issues.

## **Part II - Finding and Recommendations**

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## **Construction Requirements**

A replacement hospital at Naval Hospital Lemoore was not economically justified. The economic analysis used to justify the replacement hospital project was flawed, showing that management controls over validating construction requirements needed improvement. By building a clinic rather than a replacement hospital, DoD could put \$39.1 million to better use over the FYs 1998 through 2003 Future Years Defense Program and avoid adding unnecessary infrastructure.

### **Background**

**Criteria.** DoD instructions require that MILCON projects be justified on valid requirements and be supported by an economic analysis. OASD(HA) has an economic analysis manual that implements those procedures. DoD instructions also require that medical MILCON projects be properly validated.

**DoD Instructions.** DoD Instruction 7040.4, "Military Construction Authorization and Appropriation," March 5, 1979, requires that:

- o a special effort be made to efficiently use all existing DoD installations and facilities and

- o an economic analysis be prepared and used as an aid to establish MILCON priorities and to determine optimum allocation of resources to MILCON.

DoD Instruction 7041.3, "Economic Analysis and Program Evaluation for Resource Management," October 18, 1972, requires that an economic analysis:

- o systematically identify benefits, other outputs, and costs associated with missions and alternate ways to accomplish a program and

- o evaluate alternative financing, such as lease or buy.

DoD Instruction 6015.17, "Planning and Acquisition of Military Health Facilities," March 17, 1983, requires that an economic analysis be prepared to select the most cost-effective alternative. Changes being drafted to the instruction (to be renamed "Procedures for the Planning, Programming, Budgeting, and Execution for Construction of Military Health Facilities") will require OASD(HA) to validate and revalidate the requirements for a MILCON project at various stages of the design and MILCON process.

**Health Affairs Procedures.** The "DoD Economic Analysis Procedures Manual," (economic analysis manual) revised April 4, 1989, provides OASD(HA) procedures for the development of military treatment facility workload data, determination of availability of other health care providers, analysis of beneficiary population, and performance of cost comparisons. The publication was originally drafted in FY 1985 and has been the primary guidance for preparing an economic analysis. The OASD(HA) is in the process of updating the manual.

**NH Lemoore Catchment Area.** NH Lemoore is located at the Naval Air Station (NAS) Lemoore about 40 miles southwest of Fresno, California. Appendix B is a map of the NH Lemoore catchment area. The hospital, constructed in 1961, provides acute care medical and obstetrical services and some surgical services. The hospital has a 37-bed inpatient capability and two satellite clinics. Although it is accredited, the hospital has structural deficiencies, and violates standards of the Joint Commission on Accreditation of Health Care Organizations. The high water table in the NAS Lemoore area and the expansive soil conditions have caused cracked and uneven floors within the hospital. The hospital also contains life safety deficiencies, such as insufficient burn ratings of separating walls and inadequate smoke ventilation systems. Additionally, corridors are too narrow. The planned 174,943-square-foot replacement hospital will include outpatient clinics, ancillary and support areas, and 19 inpatient beds (9 medical/surgical and 10 obstetrics/gynecology). The design is 35 percent complete and the construction is to be completed in FY 1998.

**Health Care Availability.** Several health care services are available to the catchment area's 23,981 beneficiary population. Active duty personnel have access to NH Lemoore. Active duty dependents, retirees, and retiree dependents may receive care at NH Lemoore on a space available basis. Active duty dependents, retirees, and retiree dependents under 65 years of age are eligible for CHAMPUS benefits, while those age 65 years and over are entitled to Medicare. Retirees may also receive care at the Veterans Affairs Medical Center, Fresno, California.

**Cost of Health Care in the NH Lemoore Catchment Area.** In FY 1993, DoD spent \$29.4 million for health care in the catchment area. NH Lemoore spent \$22.4 million for 145,819 patient visits to clinics and 1,465 inpatient discharges. NH Lemoore had 2,710 inpatient bed days for an average of 7.5 (or 20.3 percent occupancy of the 37 beds) occupied beds per day. The Office of CHAMPUS spent \$7 million for 30,199 outpatient visits and 537 inpatient discharges. CHAMPUS had 2,418 inpatient bed days for an average of 6.6 occupied beds per day.

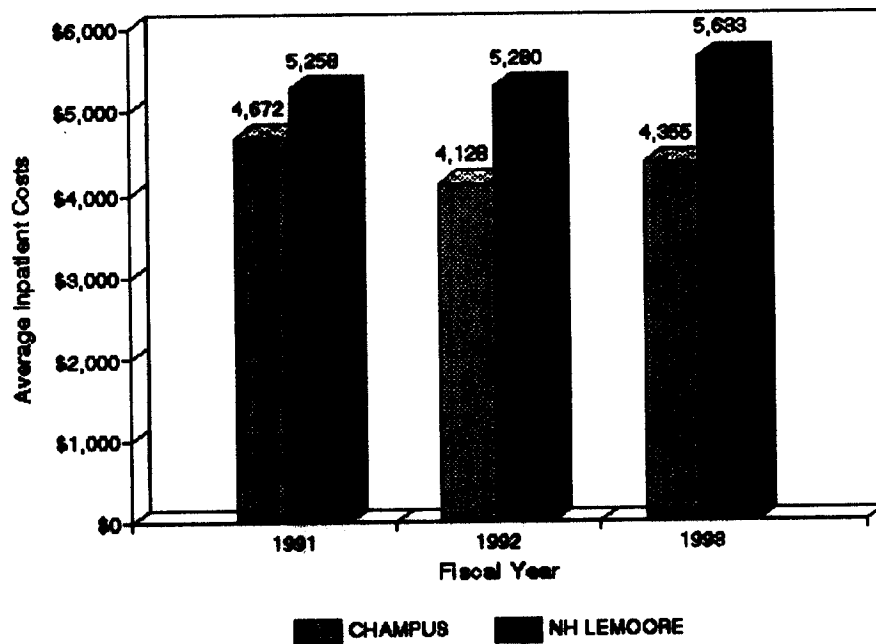
### Hospital Replacement Justification

The OASD(HA) and the Navy were planning to construct a replacement hospital that was not economically justified. The contractor-prepared economic analysis that was used to justify the replacement hospital project was flawed. Navy management controls over validating MILCON projects could be improved. Only a clinic is needed.

**Economic Analysis.** The contractor-prepared economic analysis was flawed because it overstated the savings of building a 19-bed replacement hospital. The economic analysis, completed on June 1, 1994, used a 25-year life-cycle-cost analysis. It stated that NH Lemoore would save \$14.5 million annually by constructing a replacement hospital versus building a clinic. However, the economic analysis contained a flawed inpatient cost comparison and understated the access to civilian health care. We estimated that DoD would have an annual cost avoidance of \$1.91 million (Operations and Maintenance appropriation) if a clinic were built rather than a replacement hospital.

**Inpatient Cost Comparison.** In the economic analysis, the inpatient cost comparison between NH Lemoore and CHAMPUS was flawed. The economic analysis projected inpatient care would cost less at NH Lemoore than at civilian providers. However, by using civilian health care for all inpatient care, DoD could realize an annual monetary benefit of \$1.91 million (Operations and Maintenance appropriation) or \$11.5 million over the next 6 years. Appendix C discusses the details of how the annual monetary benefit was determined.

The annual inflation cost estimate used in the economic analysis did not reflect actual annual inflation cost at NH Lemoore and CHAMPUS in FYs 1991 through 1993. As a result, the economic analysis underestimated NH Lemoore's average inpatient cost and overestimated CHAMPUS average inpatient costs. The cost inflation estimates used in the economic analysis were incorrect because the cost estimating procedure in the economic analysis manual was inadequate. Figure 1 compares actual NH Lemoore and CHAMPUS inpatient costs. We did not include FY 1990 data in Figure 1 because NH Lemoore did not have reliable information to determine accurate inpatient costs and the economic analysis did not use FY 1990 CHAMPUS data. Appendix C discusses how the average inpatient costs were computed.

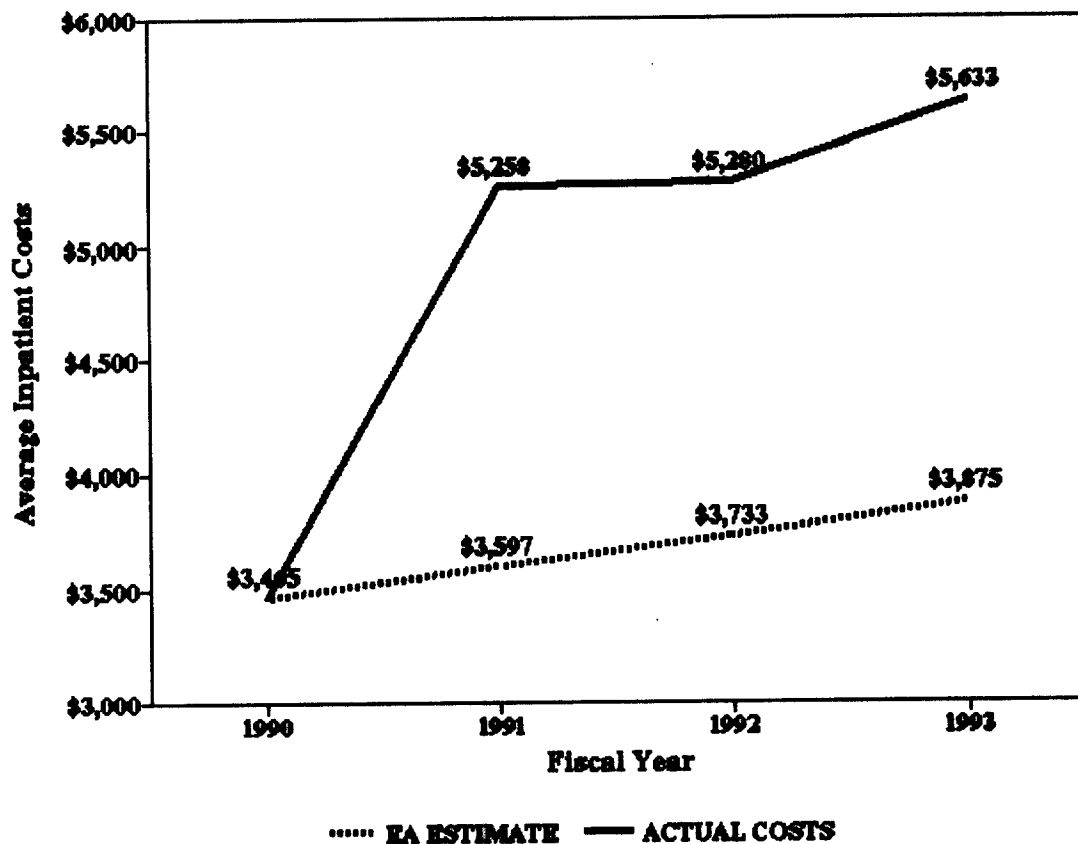


**Figure 1. Comparison of Actual Average Inpatient Costs**

**NH Lemoore Average Inpatient Costs.** The economic analysis underestimated the NH Lemoore inflation cost for average inpatient costs. The economic analysis estimated average inpatient costs to be \$3,465 in FY 1990 and \$3,875 in FY 1993 for an increase of \$410 (11.8 percent). The economic analysis applied an annual compound inflation rate of 3.8 percent to the FY 1990 estimate to project NH Lemoore's average inpatient cost through FY 1998, the construction completion date of the replacement facility. However, the actual average inpatient cost increased by \$2,168 (62.6 percent) from \$3,465 in FY 1990 to \$5,633 in FY 1993, as shown in Figure 2.



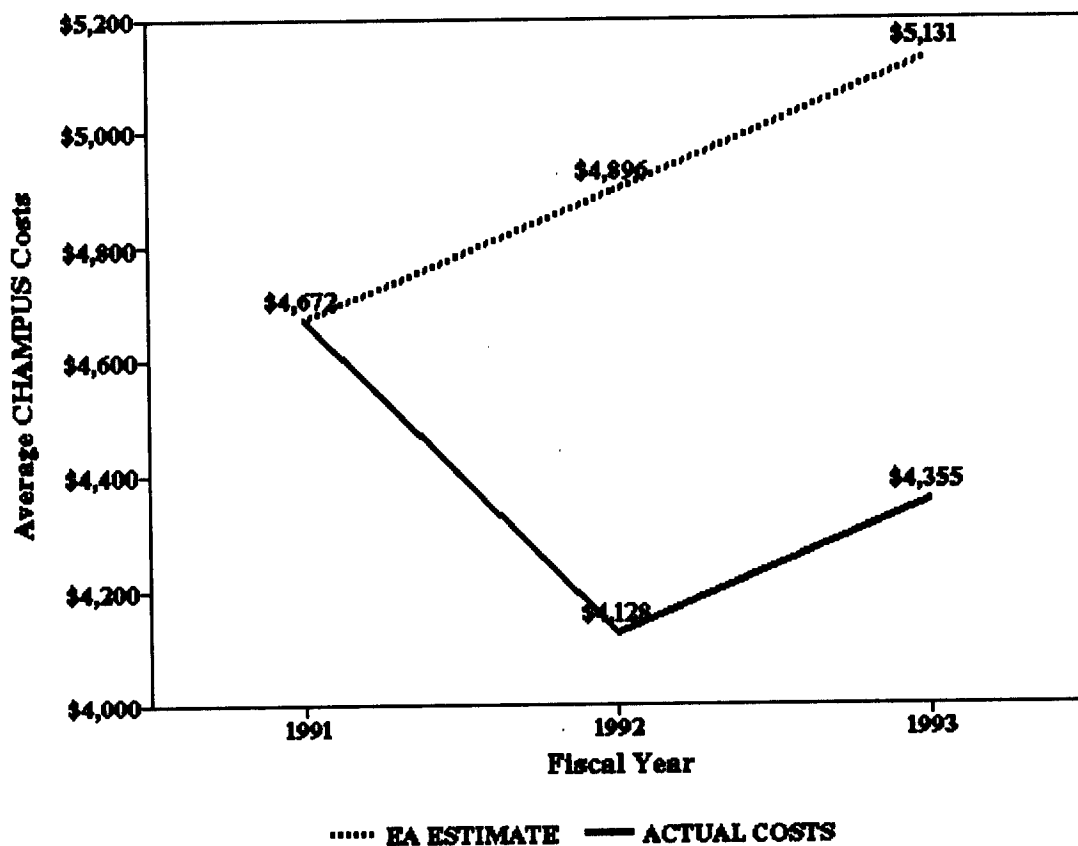
## Construction Requirements



**Figure 2. Comparison of Estimated and Actual NH Lemoore Average Inpatient Costs**

Our estimates of the NH Lemoore average inpatient costs are conservative because the Medical Expense and Performance Reporting System inpatient and outpatient cost accounts were understated by an estimated \$2.9 million, or 15.7 percent. The FY 1993 Medical Expense and Performance Reporting System patient care costs totaled \$18.5 million. However, Medical Expense and Performance Reporting System patient costs did not include \$1 million, or 5.4 percent, in NH Lemoore related expenses, such as training, patient transportation, and ambulance services. The Medical Expense and Performance Reporting System patient costs also did not reflect the amortization of the estimated construction costs of \$1.9 million annually over 25 years.

**CHAMPUS Average Inpatient Costs.** The inflation factors used in the economic analysis overstated CHAMPUS average inpatient costs. The economic analysis used actual FY 1991 CHAMPUS average inpatient cost of \$4,672 and projected a FY 1993 average inpatient cost of \$5,131, or an increase of \$459 (9.8 percent). The economic analysis applied an average annual compound inflation rate of 4.8 percent to the FY 1991 CHAMPUS actual cost through FY 1998. However, actual average inpatient costs for CHAMPUS decreased by \$317 (6.8 percent) from \$4,672 to \$4,355 between FYs 1991 and 1993, as shown in Figure 3.



**Figure 3. Comparison of Estimated and Actual CHAMPUS Average Inpatient Costs**

**Economic Analysis Manual Cost-Estimating Procedures.** The economic analysis followed the health care cost estimating procedures in the economic analysis manual, which were inadequate. The economic analysis manual requires that the average cost of all DoD community hospitals be used to estimate DoD hospital costs when performing an economic analysis for a MILCON project at a specific location. The economic analysis manual further requires that DoD hospital costs be projected based on specific Government inflation rates for military and civilian pay and the medical portion of the

## **Construction Requirements**

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consumer price index for other DoD and CHAMPUS costs. The economic analysis manual did not consider the actual cost and inflation of the area under study.

OASD(HA) was in the process of updating the economic analysis manual "to provide state-of-the-art approach for evaluating MILCON projects." Because the economic analysis manual is being updated, we are recommending that the economic analysis manual require that all cost comparisons be based on actual costs, and delete the requirement to use arbitrary inflation factors when the factors are not representative of actual cost growth in a local area. If the economic analysis had used several years of actual cost data, the actual NH Lemoore cost increase and the actual CHAMPUS cost decrease would have been identified.

**NH Lemoore Cost Increase.** We attributed the cost increase at NH Lemoore to the inefficiencies of small DoD community hospitals. In FY 1993, the average DoD inpatient bed day cost was \$860 (third party billing rate), while the average inpatient bed day cost at NH Lemoore was \$1,974, or \$1,114 (129.5 percent) more than the DoD average. General Accounting Office Report No. B-217767, "DoD Should Adopt a New Approach to Analyze the Cost-Effectiveness of Small Hospitals," March 15, 1985, stated that DoD hospitals with an average daily inpatient occupancy of less than 50 beds may not be cost-effective (see Appendix A). The economic analysis projected NH Lemoore's FY 1998 average inpatient occupancy at 12.5 beds per day.

**CHAMPUS Cost Decrease.** We attributed the cost decrease for CHAMPUS to the DoD managed care efforts and the economic conditions of the catchment area's non-DoD civilian population. Under the DoD CHAMPUS reform initiative, contract rates have been negotiated with civilian health care providers. DoD is in a favorable position to negotiate health care rates with civilian providers because approximately 40 percent of the civilian population does not have health care insurance and are on Medi-Cal, California's Medicaid program.

**Access to Civilian Providers.** The economic analysis inaccurately portrayed NH Lemoore to be in a medically underserved area. The economic analysis also overstated travel problems, such as inadequate roads and seasonal fog, for beneficiaries seeking medical care. However,

- o excess capacity existed in civilian hospitals,
- o an adequate number of physicians were available,
- o most DoD beneficiaries live off base, and
- o road conditions and seasonal fog did not impair the ability of beneficiaries from seeking civilian or military health care.

**Availability of Civilian Hospitals.** The number of acute care hospitals in the catchment area was adequate. A total of 20 acute care hospitals

were in the area with 2,310 operating patient beds, of which 18 hospitals had a daily average of 712 available patient beds. Of the 20 hospitals, 2 did not have reported patient bed utilization. The 20 hospitals ranged from a 23-patient bed hospital in Coalinga, California, to a 363-bed hospital in Fresno, California. The 20 hospitals are located various distances from NH Lemoore, 4 are located between 0 and 20 miles, 11 between 21 and 30 miles, and 5 between 31 and 40 miles. Appendix D lists the types of services the 20 hospitals offered and reported patient bed utilization.

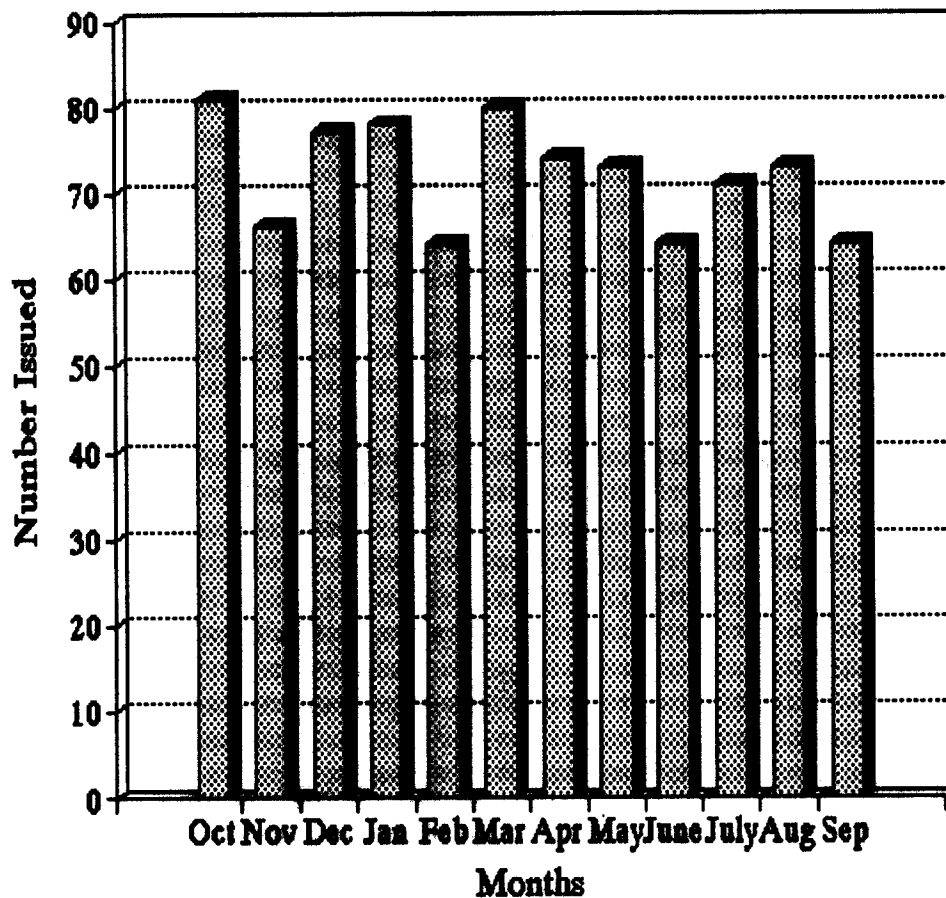
Two hospitals, Central Valley and Hanford Community, are located in Hanford, California, approximately 11 miles from NH Lemoore and have 48 excess beds. Both hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations; and each has an emergency room, an obstetrics ward, and a medical surgical ward. NH Lemoore has an agreement with Hanford Community to provide services, such as cardiac catheterization, complex and overflow obstetrics, computer axial tomography (CAT scan), magnetic resonance imaging, and radiology services, to NH Lemoore patients. The planned NH Lemoore facility will not have the capability to treat serious or complicated cases. NH Lemoore personnel stated that all burns, cardiac emergencies, complicated and high risk pregnancies, and major trauma will be transferred to various civilian hospitals in the area.

**Availability of Catchment Area Physicians.** The economic analysis stated that several of the geographic areas in the catchment area have been designated as health professional shortage areas by the Department of Health and Human Services. The NH Lemoore catchment area includes 35 Department of Health and Human Services designate areas. The economic analysis stated that 21 of the 35 areas were designated as health professional shortage areas; however, the information used in the economic analysis was out-of-date or was inaccurate. The Department of Health and Human Services defines a shortage area as one primary care physician per 3,500 persons. According to the 1990 Census Population Files, the catchment area ratio for NH Lemoore was 1:1,010 for primary care physicians to the population. Only 18 health professional shortage areas existed. Of the 18 areas, 9 were designated as health professional shortage areas, based on limited availability of medical care or insurance to migratory workers and low income persons. The criteria do not apply to the NH Lemoore beneficiaries whose health care is covered by the Government. The remaining 9 health professional shortage areas were on the fringe of the catchment area and had few DoD beneficiaries.

**Beneficiaries Living Off Base.** Approximately 17,028 (or 71 percent) of the 23,981 beneficiaries in the catchment area live off base and travel past 1 of the 20 civilian hospitals enroute to seek medical care or to go to work at the NH or NAS Lemoore. Of the 13,647 active duty personnel and their dependents assigned to NAS Lemoore, 6,694 (or 49.1 percent) live off base.

Personnel on base already travel to civilian providers for health care. In FY 1993, NH Lemoore issued 865 nonavailability statements for patients to seek treatment at civilian hospitals. A nonavailability statement is a military treatment facility certification provided to the beneficiary stating that medical

care cannot be provided because of the lack of resources or capability. Beneficiaries obtained the nonavailability statements at NH Lemoore, then traveled off base to a civilian provider for health care. Figure 4 shows a monthly distribution of patients admitted to civilian hospitals resulting from the issuance of nonavailability statements.



**Figure 4. Number of Nonavailability Statements Issued in FY 1993**

**Road Conditions and Seasonal Fog.** The safety of patients commuting to and from medical care facilities in the frequently inclement conditions near NAS Lemoore is a valid consideration. We ascertained that road conditions and seasonal fog did not significantly impair the ability of NH Lemoore beneficiaries to seek medical care at civilian health care providers or at the NH Lemoore. NAS Lemoore is easily accessible to Interstate 5 and Highways 198, 99, and 41. The highways are relatively straight and are on flat

terrain with few traffic lights and light traffic. NH Lemoore is located directly off Highway 198, which is a limited access four-lane highway, with an easy drive from NAS Lemoore into Hanford and Visalia, California.

From November through February, the NAS Lemoore and the San Joaquin Valley experience periods of dense fog. However, a 25-year employee of NAS Lemoore stated that the base had never closed or delayed opening because of the fog. As illustrated in Figure 4, a significant fluctuation of the issuance of nonavailability statements did not occur from November through February in FY 1993.

**Management Controls Over the Validation of Requirements.** OASD(HA) attempted to validate the economic analysis; however, the Navy lacked good management controls for ensuring that accurate requirements data were provided. The OASD(HA) and the Navy management control programs have designated the validation of requirements as high risk and medium risk areas, respectively.

**OASD(HA) Validation.** OASD(HA) established procedures and assigned responsibilities for the validation of MILCON project economic analyses and requirements in response to Inspector General, DoD, Report No. 92-039 (see Appendix A). Assigned monitors will track and report on the DoD management control program measures and provide an annual statement to OASD(HA).

OASD(HA) validated the economic analysis; however, the validation of the NH Lemoore replacement hospital project was performed using the economic analysis manual. As discussed in "Economic Analysis Manual Cost Estimating Procedures," the cost estimating procedures in the economic analysis manual were inadequate.

**Navy Validation.** The Naval Bureau of Medicine and Surgery did not adequately validate the replacement hospital projects submitted to OASD(HA). The Naval Bureau of Medicine and Surgery identified MILCON as an assessable unit but had not performed a management control review. However, the Naval Bureau of Medicine and Surgery has scheduled a management control review of MILCON in FY 1995. We are not making recommendations to the Navy to improve procedures for validating MILCON project requirements because recommendations were made in Inspector General, DoD, Report No. 94-125, and corrective action is in process.

## Clinic Construction

DoD could realize a one-time monetary benefit of \$27.6 million (\$46 million less \$18.4 million) if a clinic rather than a replacement hospital were built. The MILCON cost estimate for a 174,943-square-foot hospital was \$46 million. At our request, the OASD(HA) sized a clinic based on our validated population and outpatient visit figures. We calculated that there would be 35,065 beneficiaries

## **Construction Requirements**

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based on data provided by the BRAC office at Naval Air Force, U.S. Pacific Fleet, San Diego, California, and the NAS Lemoore "Naval Facilities Requirements" report. OASD(HA) estimated that the clinic should be 96,292 square feet. The cost to construct the clinic is \$18.4 million, based on OASD(HA) procedures for estimating MILCON costs. The table shows the estimated clinic construction cost.

### **Estimated Clinic Construction Cost**

Estimated construction cost:

Clinic (96,292 square feet at \$143.37 per square foot)	\$13,805,384	
Support facilities (20 percent of clinic)	<u>2,761,077</u>	\$16,566,461
Contingency fee (5 percent of construction)		828,323
Supervision, inspection, and overhead (6 percent of construction and contingency)		<u>1,043,687</u>
Total		\$18,438,471

## **Recommendations, Management Comments, and Audit Response**

1. We recommend that the Assistant Secretary of Defense (Health Affairs):
  - a. Reduce the Naval Hospital Lemoore construction project to a clinic.

**Management Comments.** The Assistant Secretary of Defense (Health Affairs) agreed that the hospital MILCON may not be economically justified. The Office of Health Services Analysis and Measurement is performing a revalidation of the MILCON project using the most recent available data. Estimated completion date of the revalidation is June 30, 1995. The Assistant Secretary also agreed that the BRAC 1993 account funds should be reduced in full, contingent upon Presidential and congressional approval of the BRAC 1995 decisions pertaining to NAS Lemoore.

**Audit Response.** The comments from the Assistant Secretary of Defense (Health Affairs) were responsive. We will review management's revalidation analysis. Our recommendation to reduce the project scope to a clinic and the related cost estimate may be conservative because of the recent DoD decision to eliminate the BRAC 1993 move to NAS Lemoore.

b. Update the "DoD Economic Analysis Procedures Manual" to require that actual cost data for a military treatment facility and its catchment area be used to perform cost comparisons between health care provided by a military treatment facility and civilian providers for construction projects.

**Management Comments.** The Assistant Secretary of Defense (Health Affairs) concurred in principle with the recommendation. The Assistant Secretary stated that actual cost data should be considered as one of the factors used to perform cost comparisons.

**Audit Response.** The comments from the Assistant Secretary of Defense (Health Affairs) are partially responsive. The Assistant Secretary neither stated that actual costs would be included as a factor in the "DoD Economic Analysis Procedures Manual," nor provided an estimated date that the action would be completed. We request that the Assistant Secretary address actions that would be taken to update the "DoD Economic Analysis Procedures Manual" and when those actions would be completed.

2. We recommend that the Under Secretary of Defense (Comptroller) reduce the Military Construction and Base Closure Account funds for the Naval Hospital Lemoore medical construction project by \$27.6 million and reprogram the funds for other valid requirements.

**Management Comments.** The Under Secretary of Defense (Comptroller) stated that DoD has recommended to the 1995 BRAC Commission that the 1993 BRAC realignment from NAS Miramar to NAS Lemoore be changed. The Comptroller placed the project funds, MILCON and Base Closure Account, on administrative hold until the Assistant Secretary of Defense (Health Affairs) reviews the requirements to determine the type of military treatment facility that will be needed. Any savings associated with the replacement project will be reprogrammed.

**Audit Response.** The comments from the Under Secretary of Defense (Comptroller) are responsive. However, any decision to fund a replacement project based on the revalidation by the Assistant Secretary of Defense (Health Affairs) should be delayed until we have reviewed the results of the revalidation.



## **Part III - Additional Information**

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## **Appendix A. Prior Audits and Other Reviews**

## **Appendix A. Prior Audits and Other Reviews**

General Accounting Office Report No. B-217767, "DoD Should Adopt a New Approach to Analyze the Cost-Effectiveness of Small Hospitals," March 15, 1985, stated that 69 hospitals with an average daily patient load of 50 or less may not be cost-effective to operate. The General Accounting Office further stated that DoD had no procedures to evaluate the cost-effectiveness of those 69 hospitals. The General Accounting Office recommended that DoD develop a model and criteria for evaluating the cost-effectiveness of small military hospitals and converting uneconomical hospitals to clinics. DoD agreed with the recommendation.

OASD(HA) Report, "Military Health Services System Continental United States Small Hospital Analysis," July 1993, analyzed 57 small hospitals (50 or fewer operating beds) to determine the feasibility and cost-effectiveness of converting to an outpatient clinic. Inpatient care would be provided through an alternative source. The report identified 19 small military hospitals for detailed functional economic analysis for potential downsizing. NH Lemoore scored in the middle range of the hospitals studied and was not recommended for further study. The report did show that CHAMPUS inpatient care was cheaper than NH Lemoore inpatient care.

Inspector General, DoD, Report No. 95-212, "Defense Base Realignment and Closure Budget Data for Fort Jackson, South Carolina," June 2, 1995, reported that the Army plans to construct a Primary Care Center that is not a valid BRAC requirement. By canceling the Primary Care Center project, DoD could put \$5.4 million of Base Closure Account, \$2.6 million of Other Procurement, and \$2.1 million of Operations and Maintenance funds to better use. The Under Secretary of Defense (Comptroller) concurred with the recommendations but deferred action pending receipt of Army comments. The OASD(HA) did not respond to the draft report.

Inspector General, DoD, Report No. 95-213, "Defense Base Realignment and Closure Budget Data for the Naval Training Center Great Lakes, Illinois," June 2, 1995, reported that the Navy planned to construct a child care center, site improvements for a relocatable brig, and a branch medical clinic that were not needed. DoD could reduce FY 1996 Base Closure Account funds by up to \$5.1 million and Operations and Maintenance funds by up to \$2.7 million for FYs 1997 through 2002 by canceling the child development center and the site improvements for the brig and deferring the branch medical clinic. The Under Secretary of Defense (Comptroller) concurred with the recommendations but deferred action pending receipt of Navy comments and resolution of the dollar savings. The OASD(HA) and the Navy did not respond to the draft report.

Inspector General, DoD, Report No. 94-125, "Defense Base Realignment and Closure Budget Data for the Naval Medical Center Portsmouth, Virginia," June 8, 1994, reported that DoD planned to construct a \$6.3 million bachelor enlisted quarters and a \$3.7 million parking garage that were not needed. The bachelor enlisted quarters and parking garage projects were part of the BRAC package for the MEDCEN Oakland closure. The report recommended that the

MILCON projects be canceled. The Navy agreed and canceled the projects. The report identified weaknesses in management controls for BRAC MILCON projects at the Bureau of Medicine and Surgery and Naval Facilities Engineering Command, Atlantic Division. The commands agreed to stress procedures for the control of BRAC MILCON projects.

Inspector General, DoD, Report No. 93-099, "Quick Reaction Report on Base Realignment and Closure Budget Data for the Collocations of Army and Navy Blood and Dental Research Programs," May 24, 1993, reported that a BRAC MILCON project for a blood research and applications laboratory facility was not needed and a project for dental research programs was in excess of requirements. We recommended that other alternatives be pursued rather than new construction. By implementing the recommendations, DoD could put to better use \$18.7 million in BRAC funds. The Navy concurred with the recommendations.

Inspector General, DoD, Report No. 94-063, "Medical Treatment Facility Requirements-Fitzsimons Army Medical Center," March 21, 1994, showed that it was not economically justified to construct a replacement MEDCEN at Fitzsimons Army MEDCEN. As a result, DoD could save \$301.4 million in construction, design, and equipment funds by discontinuing further design work on the Fitzsimons Army MEDCEN replacement project. The OASD(HA) agreed with the report. The Office of the Under Secretary of Defense for Acquisition and Technology nonconcurred to cancel the Fitzsimons Army MEDCEN replacement project but reduced the MILCON funding estimate from \$390 million to \$225 million. The National Defense Authorization Act for FY 1995 required the Secretary of Defense to certify that the Fitzsimons Army MEDCEN replacement project is needed and to address specific issues in the audit report if funds are requested. In Program Budget Decision No. 305C, December 17, 1994, the Fitzsimons Army MEDCEN replacement project funding was deleted.

Inspector General, DoD, Report No. 93-160, "Medical Facility Requirements-Portsmouth Naval Hospital," September 2, 1993, reported that DoD planned to construct an acute care facility that exceeded valid needs. The report recommended reducing the size of the planned facility and renovating existing facilities for outpatient services. The OASD(HA) nonconcurred with the recommendation. In audit resolution, the Deputy Secretary of Defense authorized OASD(HA) to construct the acute care facility as planned, without reducing its size. The OASD(HA) concurred with a recommendation establishing controls to ensure that medical MILCON projects are designed and constructed within the scope of a validated economic analysis.

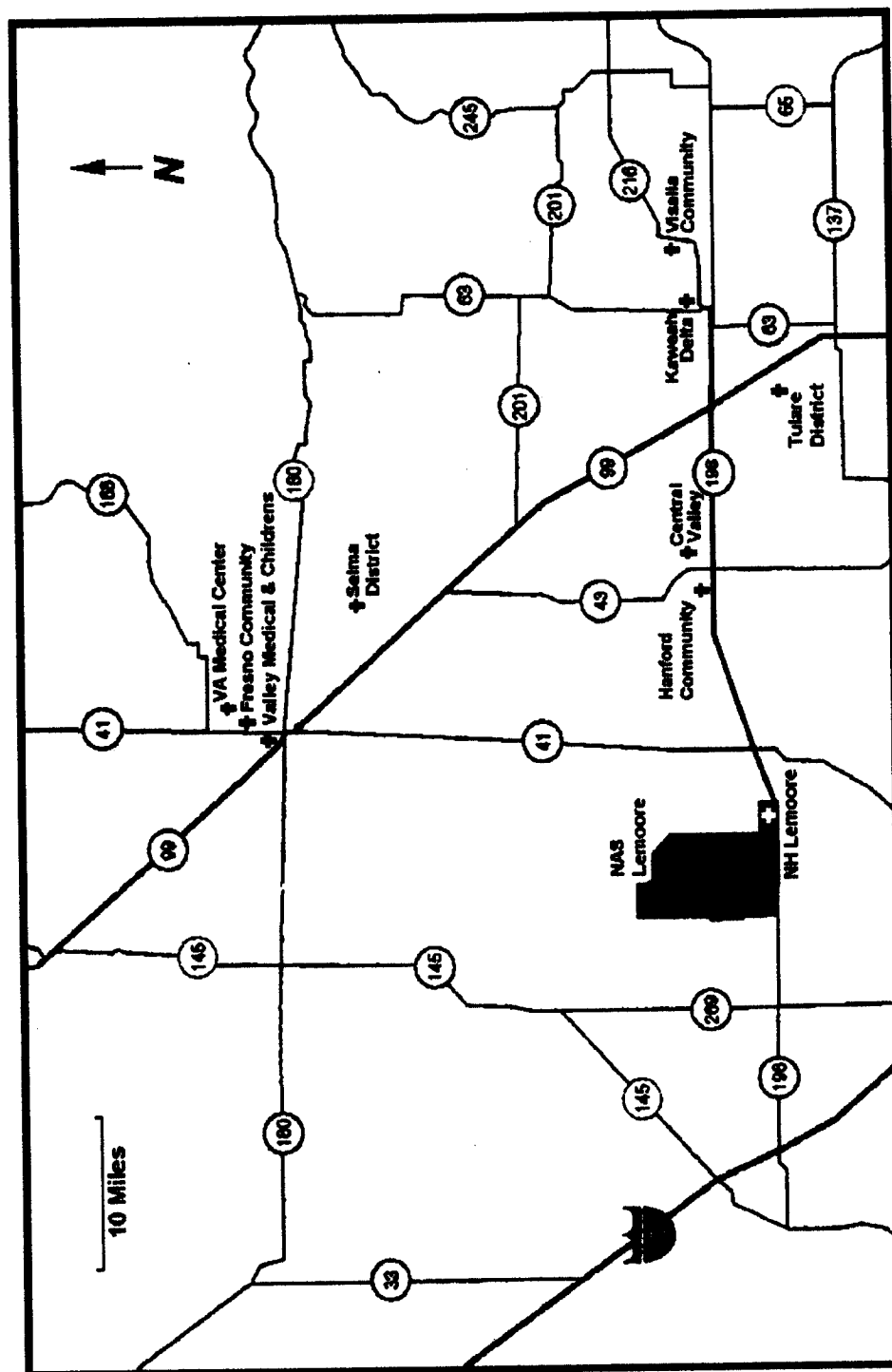
Inspector General, DoD, Report No. 93-047, "Medical Facility Requirements-Stockton Fleet Hospital Prepositioning Facility," January 28, 1993, reported that OASD(HA) planned to construct a deployable medical system warehouse and support facilities that were not needed. OASD(HA) did not revalidate requirements or perform an economic analysis. As the result of the recommendation, OASD(HA) revalidated the requirements and found the construction project was not needed. OASD(HA) canceled the \$22 million MILCON project.

## **Appendix A. Prior Audits and Other Reviews**

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Inspector General, DoD, Report No. 92-039, "Quick-Reaction Report on Construction of Nellis Air Force Base, Nevada, Hospital," January 30, 1992, showed that OASD(HA) had not revalidated the project's requirements before construction. The report concluded that the Nellis MILCON project was not economically justified. The OASD(HA) nonconcurred with the reported conclusion, but agreed to establish procedures to revalidate the requirements and the economic analysis for future medical MILCON projects.

**Appendix B. Map of the Naval Hospital Lemoore Catchment Area and Selected Civilian Hospitals**



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## **Appendix C. Methodology for Calculating Average Inpatient Costs and Cost Differential**

### **Actual Average Inpatient Cost Estimates**

The actual average inpatient cost used in this report is a weighted average cost per inpatient discharge (average inpatient cost) for FYs 1991 through 1993. The actual average inpatient cost is determined from three factors:

- o inpatient discharge cost,
- o annual case mix index (CMI), and
- o annual correction factor.

**Inpatient Discharge Cost.** The average inpatient discharge costs come from the "Medical Expense Performance Reporting System Part I-Medical Expense Report" for NH Lemoore, and the CHAMPUS (Government annual cost) "Health Care Summary Report" for the catchment area. The average inpatient discharge cost is the total inpatient cost divided by the number of inpatient discharges. The average inpatient discharge cost has to be weighted by the level of case complexity.

**Case Mix Index.** The annual CMI is a measure of total patient case load complexity. CMI is a sum of diagnosis related group numbers divided by the number of discharges. The Health Care Finance Administration has assigned a case mix number to each diagnosis related group that reflects average resource consumption, patient length of stay, and complexity of care for a medical problem. The CMI comes from the Defense Medical Information System for both NH Lemoore and CHAMPUS.

**Correction Factor.** OASD(HA) uses the annual correction factor to adjust the annual CMI when the CMI is being compared for more than 1 year. OASD(HA) calculates a new correction factor each year, because of the yearly change in some case mix numbers.

**Formula.** The formula for calculating the average inpatient cost is:

actual average inpatient cost = average inpatient discharge cost divided by the  
quotient of the average CMI divided by the correction factor

Table C-1 shows the calculations used to determine the actual average inpatient cost for NH Lemoore.

## Appendix C. Methodology for Calculating Average Inpatient Costs and Cost Differential

**Table C-1. NH Lemoore Actual Average Inpatient Cost**

<u>Fiscal Year</u>	<u>Average Inpatient Discharge Cost</u>	<u>CMI</u>	<u>Correction Factor</u>	<u>Actual Average Inpatient Cost</u>
1991	\$3,158	.4819	.8024	\$5,258
1992	3,109	.4739	.8048	5,280
1993	3,652	.5153	.7949	5,633

Table C-2 shows the calculations used to determine the actual average inpatient cost for CHAMPUS.

**Table C-2. CHAMPUS Actual Average Inpatient Cost**

<u>Fiscal Year</u>	<u>Average Inpatient Discharge Cost*</u>	<u>CMI</u>	<u>Correction Factor</u>	<u>Actual Average Inpatient Cost</u>
1991	\$9,939	1.7070	.8024	\$4,672
1992	6,833	1.3320	.8048	4,128
1993	6,151	1.1227	.7949	4,355

\*The average inpatient discharge cost includes only DoD cost.

### Cost Differential Between NH Lemoore and CHAMPUS

To determine the annual cost difference between NH Lemoore and CHAMPUS inpatient costs, the cost difference must be calculated for three categories of beneficiaries: nonactive duty beneficiaries under age 65, beneficiaries age 65 and over, and active duty personnel. The following formula was used to calculate the annual cost difference.

Annual cost difference = number of inpatient discharges multiplied by (average CMI divided by the correction factor) multiplied by cost difference between the actual NH Lemoore and CHAMPUS average inpatient costs

**Nonactive Duty Beneficiaries Under Age 65.** The nonactive duty beneficiaries under age 65 consist of active duty dependents, retirees, and retiree dependents. This beneficiary group is CHAMPUS eligible and must share the cost with DoD for CHAMPUS services. The annual cost differential was calculated by multiplying the difference between the NH Lemoore and CHAMPUS FY 1993

## Appendix C. Methodology for Calculating Average Inpatient Costs and Cost Differential

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actual average inpatient costs (see Tables C-1 and C-2) of \$1,278 (\$5,633 less \$4,355), by the audit-determined nonactive duty discharges (2,031) for FY 1998, multiplied by the adjusted CMI of .6483 (CMI of .5153 divided by .7949).

**Beneficiaries Age 65 and Over.** DoD incurs no out-of-pocket expense for Medicare eligibles. Beneficiaries age 65 and over are not entitled to CHAMPUS benefits. We multiplied the full NH Lemoore actual average inpatient cost of \$5,633 by the audit-determined FY 1998 calculated discharges of 36, multiplied by the adjusted CMI of .6483.

**Active Duty Personnel.** Because active duty personnel make no copayments and pay no deductibles, we used the full FY 1993 CHAMPUS Government and beneficiary charge (full CHAMPUS cost) of \$4,986 per discharge. The estimated difference between the full CHAMPUS cost and NH Lemoore cost was \$647 (\$5,633 less \$4,986) per discharge. The \$647 difference was multiplied by the number of audit-calculated active duty discharges of 222 for FY 1998, multiplied by the adjusted CMI of .6483. Table C-3 shows the calculation of the annual cost difference.

**Table C-3. Estimate of Annual Cost Difference**

<u>Beneficiary Category</u>	<u>Discharges</u>	<u>Adjusted CMI</u>	<u>Cost Difference</u>	<u>Annual Cost Difference (\$000)</u>
Nonactive duty	2,031	.6483	\$1,278	\$1,683
Medicare	36	.6483	5,633	131
Eligibles				
Active Duty	222	.6483	647	93
<b>Total</b>	<b>2,289</b>			<b>\$1,907</b>

The annual cost difference of \$1,907,000 is the potential monetary benefit if the NH Lemoore inpatient work load was referred to civilian hospitals.



## Appendix D. Catchment Area Hospitals

Hospital Name	Distance to NH Lemoore (miles)	Total Patient Beds	Average Vacant Beds	Average Vacancy Rate (percent)	JCAHO <sup>1</sup> Accredited	Medical Services		
						Obstetrics Ward	Emergency Room	Medical Surgical
Alta District	26	40	27	67.7	Yes	No	Yes	Yes
Avenal District <sup>2</sup>	28	28			No	No	No	No
Central Valley	11	66	42	63.6	Yes	Yes	Yes	Yes
Clovis Community	35	97	74	76.0	Yes	Yes	No	Yes
Coalinga District	36	23	13	57.0	No	Yes	Yes	Yes
Corcoran District	18	32	16	50.0	No	No	Yes	Yes
Fresno Community	29	363	103	28.4	Yes	Yes	Yes	Yes
Fresno Veterans	29	191	57	30.0	Yes	No	Yes	Yes
Hanford Community	11	54	6	11.1	Yes	Yes	Yes	Yes
Kaiser Permanente <sup>2</sup>	29	110			Yes	Yes	Yes	Yes
Kaweah Delta	29	181	3	1.5	Yes	Yes	Yes	Yes
Memorial at Exeter	35	30	9	30.8	Yes	No	Yes	Yes
St. Agnes	29	323	89	27.6	Yes	Yes	Yes	Yes
Selma District	20	45	24	53.8	Yes	Yes	Yes	Yes
Sierra Community	33	54	28	51.5	Yes	No	Yes	Yes
Sierra Kings	29	36	24	66.3	Yes	Yes	Yes	Yes
Tulare District	23	86	34	39.5	Yes	Yes	Yes	Yes
Valley Childrens	31	173	31	18.2	Yes	No	Yes	Yes
Valley Medical	29	326	103	31.5	Yes	Yes	Yes	Yes
Visalia Community	27	<u>52</u>	<u>29</u>	56.0	Yes	Yes	Yes	Yes
<b>Total</b>		<b>2,310</b>	<b>712</b>					

<sup>1</sup> Joint Commission on Accreditation of Health Care Organizations.

<sup>2</sup> Average vacant beds and vacancy rate not reported.

## Appendix E. Summary of Potential Benefits Resulting From Audit

Recommendation Reference	Description of Benefit	Amount and/or Type of Benefit
1.a.	Economy and Efficiency. Reduce funding.	<p>Funds put to better use. A one-time benefit of \$27.6 million in Military Construction Appropriation (96-X-0500) and Base Closure Account funds.</p> <p>Also, an annual benefit of \$1.91 million, or \$11.5 million for FYs 1998 through 2003, Defense Medical Program Operations and Maintenance Appropriation (97-0130).</p>
1.b.	Economy and Efficiency. Ensure that cost comparisons in economic analyses are prepared properly.	Undeterminable. The amount of monetary benefits will be determined by future budget requests and budget decisions.
2.	Economy and Efficiency. Reduce funding.	Funds put to better use. Monetary benefits are included in Recommendation 1.a.

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## **Appendix F. Organizations Visited or Contacted**

### **Office of the Secretary of Defense**

Under Secretary of Defense (Comptroller), Washington, DC  
Assistant Secretary of Defense (Health Affairs), Washington, DC  
Health Budget and Programs, Washington, DC  
Health Services Operations and Readiness, Washington, DC  
Defense Medical Facilities Office, Falls Church, VA  
Health Services Analysis and Measurement, Falls Church, VA

### **Department of the Navy**

Deputy Chief of Naval Operations (Logistics), Washington, DC  
Commander in Chief, U.S. Pacific Fleet, Honolulu, HI  
Commander, Naval Air Force, U.S. Pacific Fleet, San Diego, CA  
Naval Air Station, Lemoore, CA  
Comptroller of the Navy, Washington, DC  
Bureau of Medicine and Surgery, Washington, DC  
Naval Hospital Lemoore, CA  
Naval Facilities Engineering Command, Alexandria, VA  
Western Division, Naval Facilities Engineering Command, San Diego, CA

### **Other Defense Organizations**

Office of the Civilian Health and Medical Program of the Uniformed Services,  
Aurora, CO  
Defense Manpower Data Center, Arlington, VA

### **Non-Defense Organizations**

Department of Health and Human Services, Division of Shortage Designation,  
Bethesda, MD  
Department of Veteran Affairs, Medical Center, Fresno, CA

### **Non-Government Organizations**

Alta District Hospital, Dinuba, CA  
California Department of Finance Demographic Unit, Sacramento, CA  
Clovis Community Hospital, Clovis, CA  
Coalinga Hospital, Coalinga, CA  
Corcoran District Hospital, Corcoran, CA

**Non-Government Organizations (cont'd)**

Fresno County Planning District, Fresno, CA  
Kaiser Permanente Hospital, Fresno, CA  
Kings County Health Department, Hanford, CA  
Kings County Planning District, Hanford, CA  
Medical Board of California, Sacramento, CA  
Medical Society of Kings County, CA  
Memorial Hospital at Exeter, Exeter, CA  
Selma District Hospital, Selma, CA  
Sierra Community Hospital, Fresno, CA  
Sierra Kings District Hospital, Reedly, CA  
Tulare County Planning District, Visalia, CA  
Visalia Community Hospital, Visalia, CA

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## **Appendix G. Report Distribution**

### **Office of the Secretary of Defense**

Under Secretary of Defense for Acquisition and Technology  
Director, Defense Logistics Studies Information Exchange  
Under Secretary of Defense (Comptroller)  
Deputy Under Secretary of Defense (Comptroller/Management)  
Deputy Comptroller (Program/Budget)  
Assistant Secretary of Defense (Economic Security)  
Assistant Secretary of Defense (Health Affairs)  
Assistant to the Secretary of Defense (Public Affairs)

### **Department of the Army**

Auditor General, Department of the Army

### **Department of the Navy**

Assistant Secretary of the Navy (Financial Management and Comptroller)  
Auditor General, Department of the Navy

### **Department of the Air Force**

Assistant Secretary of the Air Force (Financial Management and Comptroller)  
Auditor General, Department of the Air Force

### **Defense Organizations**

Director, Defense Contract Audit Agency  
Director, Defense Logistics Agency  
Director, National Security Agency  
- Inspector General, National Security Agency

## **Non-Defense Organizations and Individuals**

Office of Management and Budget  
National Security and International Affairs Division, General Accounting Office  
Technical Information Center  
Defense and National Aeronautics and Space Administration Management Issues  
Military Operations and Capabilities Issues

Chairman and ranking minority member of each of the following congressional committees and subcommittees:

Senate Committee on Appropriations  
Senate Subcommittee on Defense, Committee on Appropriations  
Senate Subcommittee on Military Construction, Committee on Appropriations  
Senate Committee on Armed Services  
Senate Committee on Governmental Affairs  
House Committee on Appropriations  
House Subcommittee on Military Construction, Committee on Appropriations  
House Subcommittee on National Security, Committee on Appropriations  
House Committee on Government Reform and Oversight  
House Subcommittee on National Security, International Affairs, and Criminal  
Justice, Committee on Government Reform and Oversight  
House Committee on National Security

Senator Barbara Boxer, U.S. Senate  
Senator Dianne Feinstein, U.S. Senate  
Congressman Calvin Dooley, U.S. House of Representatives

## **Part IV - Management Comments**

# Under Secretary of Defense (Comptroller) Comments



COMPTROLLER  
(Program/Budget)

OFFICE OF THE UNDER SECRETARY OF DEFENSE  
1100 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1100



MAR 31 1995

MEMORANDUM FOR ASSISTANT INSPECTOR GENERAL FOR AUDITING, DOD IG

SUBJECT: Draft Report on the Audit of Base Realignment and  
Closure Budget Data for the Naval Hospital Lemoore,  
California (Project No. 4CG-5008.20)

This responds to your February 14, 1995, memorandum  
requesting our comments on the subject report.

The audit recommends that funding be reduced by \$27.6  
million for the hospital replacement project for NAS Lemoore,  
California, on the basis that the project is not economically  
justified. The audit recommends that a medical clinic be  
constructed instead of a replacement hospital.

The Department has recommended to the 1995 BRAC Commission  
that receiving sites for the NAS Miramar realigning activities  
specified by the 1993 BRAC Commission change from NAS Lemoore,  
California, and NAS Fallon, Nevada, to other naval air stations.  
If this recommendation is approved, there will be no need for  
a replacement hospital or clinic at NAS Lemoore as originally  
planned. Currently, ASD(HA) is reviewing the requirements to  
determine the type of medical treatment facility required if the  
BRAC 1995 recommendation is approved.

As a consequence, we are placing the funds for the  
replacement hospital on administrative hold pending BRAC 1995  
decisions. Any savings associated with the replacement hospital  
will be reprogrammed to other valid requirements as appropriate.

CC:  
ASD(Health Affairs)  
ASN(Financial Management)

  
BRUCE A. DAUER  
ASSISTANT DEPUTY COMPTROLLER  
(PROGRAM/BUDGET)





# Assistant Secretary of Defense (Health Affairs) Comments



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
WASHINGTON, DC 20301-1200

JUN 2 1995

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL

SUBJECT: Revised Draft Department of Defense Inspector General  
Audit Report on Base Realignment and Closure Budget  
Data for the Naval Hospital Lemoore, California

Thank you for the opportunity to comment on your revisions to the draft audit report concerning Naval Hospital, Lemoore, California, project number 4CG-5008-20. Specific comments are attached.

As noted in an earlier letter on this same subject, Base Realignment and Closure data were subject to frequent updates during the time we developed our separate analyses and we attribute the differences in several of our conclusions to these changes. My Health Services Analysis and Measurement office is completing a Military Construction revalidation analysis using the most recently available population, workload, staffing, and cost data, and incorporating a new draft program for design developed by the Defense Medical Facilities Office. This revalidation remains on schedule with completion anticipated on 30 June 1995.

We appreciate your past review of the Lemoore project. If you have any questions, please contact Commander Rod Fierek at (703) 756-2081 or DSN 289-2081.

George K. Anderson, MajGen, USAF, MC  
Deputy Assistant Secretary of Defense  
(Health Services Operations and Readiness)

Attachment:  
As Stated

We concur with the finding that BRAC 93 funds, originally programmed to support active duty population migration to Naval Air Station (NAS) Lemoore, should be reduced in full, contingent upon Congressional acceptance and Presidential approval of the BRAC 95 recommendations released by the Secretary of Defense, as they pertain to NAS Lemoore.

We concur in principle with the finding that a replacement hospital may not be economically justified. We also recognize that numerous non-BRAC issues underpinning our mutual analyses have changed over the past year, warranting reassessment of the proposed medical Military Construction (MILCON) project in the Naval Hospital (NH) Lemoore catchment area. The Office of Health Services Analysis and Measurement (OASD(HA)HSO&R/HSAM) is performing a MILCON revalidation analysis using the most recently available data.

We concur in principle that actual cost data should be considered as one of the factors used to perform cost comparisons between health care provided by military and civilian treatment facilities when considering potential construction projects.

Since your audit focused on the 1994 economic analysis, we request that you clearly associate your final audit report with that analysis, thus avoiding potential confusion with our current revalidation, a work in progress due for completion in June 1995.

## **Audit Team Members**

**This report was prepared by the Logistics Support Directorate, Office of the Assistant Inspector General for Auditing, Department of Defense.**

**Shelton R. Young  
Michael A. Joseph  
Jack L. Armstrong  
Douglas L. Jones  
Robert T. Briggs  
Anna P. Martin**